MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

**Thursday, March 20, 2003**

**9:17 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

Growth in the use of physician services
-- Kevin Hayes, Joan Sokolovsky, Chantal Worzala

DR. WORZALA: Good afternoon. I'm going to start this presentation and then I'll turn it over to Kevin about halfway through. As a reminder this is a continuation of some work on growth and the use of physician services that you saw in November of last year and then also as part of the March report. We're building on the workplan that you looked at in November and are moving towards a chapter in the June report.

Historically, growth in spending on physician services has been a difficult issue for Medicare to address. Various different policies have been adopted over time, including expenditure targets and managed care, among others, and in this project we're looking in more depth at trends in the growth in use of physician services and the specific factors that might account for that growth. The idea is that a better understanding of why service use is growing should allow us to better target policies aimed at controlling growth in spending.

This is very much a work in progress. What you have here is an outline of the proposed chapter. As I go through it I'll try and give you a sense of where we are. You've seen general trends in service use growth and trends by type of service. I'll review those in just a moment. And then your briefing papers included some new results that we'll present today looking at growth by geographic area. Then we'll present the results of our first analysis looking at factors affecting growth starting with professional liability. Another analyses are also planned, of course, as outlined in the briefing papers.

Finally we'll review the kinds of policy options that this work might inform. I'm sure you noticed that that part of the chapter is in outline form at the moment and we're very interested in your guidance there.

We won't be bringing you any historical data right now because you've already seen it, but the general trend in the use of physician services so there was very high growth in the 1980s. That did moderate in the 1990s after introduction of the physician fee schedule. Then we do see future acceleration projected by the CMS actuaries.

This table shows the analysis of growth from 1999 to 2002 as published in the March report. To remind you, the measure of service use is the sum of relative value units for all services delivered without adjustment for local prices. We applied the 2002 RVUs and conversion factor to each year to allow for comparisons over time. The measure represents resources used per fee-for-service beneficiary and it captures changes in both the volume and the intensity of services delivered. The data come from the 5 percent sample of the physician supplier claims in each year. The average annual growth rate from 1999 to 2002 was 3.6 percent for all services. When you look at it by type of service there's considerable variation, and these are betos categories. That's a classification system developed by CMS.

Evaluation and management services experienced the lowest rate of growth at just under 2 percent per year. The volume and intensity of procedures grew at about 4 percent that annually for procedures, and tests and grew at 5.6 percent. The highest growth rate that we observed was for imaging services which had an average annual rate of growth of 9 percent.

MS. DePARLE: The first column, what are those numbers?

DR. WORZALA: That's the actual value in 2002, so when you take the relative value units and sum them up and multiply by the 2002 conversion factor it's a measure of the resources used per fee-for-service beneficiary. So it's analogous to a dollar amount but it's not the same as expenditures because we've taken away some of the things --

DR. NEWHOUSE: If everybody were paid at the same price this would be dollars?

DR. WORZALA: Exactly. Right. So we've taken away any of the local adjustment to payment for input prices, but it is analogous to a dollar. So you could say that fee-for-service beneficiaries, if everybody were paid the same, we spent $739 on physician services for a beneficiary. Does that makes sense?

MS. DePARLE: Sort of.

DR. WORZALA: Kevin, did you want to add anything?

DR. HAYES: No, I think that really captures it. So it's the dollar's worth of care that someone is receiving in each of these categories.

DR. NEWHOUSE: I think Nancy-Ann's problem, maybe she's not sure what the units are and maybe it's just best interpreted as an index number.

MR. HACKBARTH: In the market that has a geographic adjustment of 1.0, right? So in that market we'd be talking about spending $739 per --

DR. WORZALA: Then if you look at the numbers under all services, do sum to 739, so we're just apportioning all services across the service lines.

MS. DePARLE: So if I read this, the spending on something like tests was relatively small but the average annual growth of that over the 1999 to 2002 period was relatively larger than some of the other where the actual spending was hired.

DR. WORZALA: Right.

MR. DeBUSK: Why is this?

DR. WORZALA: That's what we want to find out. Hopefully by the end of the April meeting we'll be able to tell you, at least some of it.

MR. DeBUSK: It might have something to do with the legal profession.

DR. WORZALA: I'm sure we'll get into that a bit later.

Given the large growth in volume for imaging services, we chose to focus our initial geographic analyses only on that line of service. So what this map shows is the level of service use in 2001. Due to data limitations really for the denominator, fee-for-service beneficiaries in area we could not use 2002 data and are limited to 2001. We are hoping to expand to 2002 soon.

The unit of analysis here is the payment locality. That's the geographic unit used to adjust payments for differences in input prices, so things like the practice expense, GPCI, the PLI GPCI. There are 87 payment localities, of which 34 represent entire states. The other payment localities represent large urban areas such as New York or Chicago, or portions of larger states. Particularly, California and Texas have a number of payment localities within the state.

The measure of service use is the same. It's representing resources used for imaging services on a per-beneficiary basis, counting only fee-for-service beneficiaries. Those areas with the lightest shading are the lowest quartile of service use. Those with the darkest shading are in the highest quartile of service use.

As with the geographic variation analysis you saw this morning, we did map service use to the beneficiary place of residence, not to the place of service delivery. We use the denominator file to identify the population by locality.

This table shows the pattern of growth in use of imaging services by geographic area as well as the relationship between the level of use at the beginning of the period, or 1999, and the rate of growth over the period 1999 to 2001. Again, we're looking at payment localities with the same measure of service use for imaging services. You look at the four quartiles based on average use of imaging services in '99. Quartile one has the lowest use, quartile four has the highest use. That's reflected in the second column there.

The use of imaging services did vary by a factor of almost two between those with the lowest service use and those with the highest use, so varying from 57-sort-of dollars on average to 113. But when you look at the average rates of annual growth there's a slightly opposite pattern where those with low use initially, or quartile one, have a higher rate of growth over the period, and those with the highest use have the lowest rate of growth. So the difference in growth rates you'll see is not quite as stark or as large as the difference that you saw in the level of service use.

We have two different hypotheses that might explain this trend of lower growth in areas with higher use and vice versa. One is these is more statistical where you could have some regression to the mean, and the other might be some sort of saturation hypothesis where those areas with high level of use simply have less room for additional growth in use of services.

Finally, the last column on the table captures the contribution of both the initial level of service use and the subsequent growth in service use to the overall growth. So when you look at the overall growth in imaging from '99 to 2001 the average annual rate was 9 percent. The question is, for each quartile when you look at both their level and their rate of growth, how much are they contributing to that 9 percent growth overall?

What you see here his that quartile one, which does have the highest rate of growth but is combined with a lower level of service use, is actually a relatively small contributor to the overall growth. By contrast, the third and fourth quartiles which had lower growth but much higher initial service use contribute more significantly and they do account for about two-thirds of the overall growth. This does illustrate that if policymakers are concerned with the rate of growth in service use, you shouldn't focus simply on areas with the highest rate of growth. Areas with high use are equally important.

Our analysis of geographic variation and service use is both descriptive, as I've presented here, and analytic, supporting our investigation of the factors that might account for the growth to start to answer Pete's question. The first area that we were going to look at is professional liability and that's where Kevin comes in.

DR. REISCHAUER: Can I ask a question? Do the quartiles have the same number of beneficiaries in them or are they service area?

DR. WORZALA: They're not beneficiary weighted in defining the quartile, but then when you construct the services --

DR. REISCHAUER: But then the last column you can make no sense out of it at all.

MR. HACKBARTH: Did you beneficiary weight the last column?

DR. WORZALA: Yes, the last column is. The last column is, but in defining the quartiles we didn't do that.

DR. ROWE: You may have done this and I may have missed it, but in your analysis -- I don't know if this is possible. You might be able to look at it in one specific area. In my experience there are two things that you have to look at. One is the total use of imaging services, and the second is the total number of imaging machines. You get a very different analysis.

What happens is when there's a new machine or machines are added to a market where there might be relatively low use, they tend to get scheduled up pretty quickly and there's not a lot of resistance to having any particular test scheduled, because we want to use the machine. When you get a saturated market, then people start to have to wait for these tests and physicians are much more rigorous about who's going to get the MRI versus who can have a CAT scan or a regular film because they don't want to wait, et cetera. So it's a kind of demand and supply issue with respect to the number of machines. That might explain why the areas with the lowest utilization on an absolute basis have the highest growth, because those are ones where machines are just becoming available and there's relatively low threshold to get scheduled, et cetera.

So that's just the way it works within a medical center and a hospital and a community. I don't know if you have the data available on the number of units as opposed to the number of tests, but if you did it might make an interesting secondary analysis. You might explain some of the variance here.

MS. BURKE: Glenn, may I ask a question or do you want to wait and just finish the whole --

MR. HACKBARTH: If we can wait I'd just as soon get the presentations out.

DR. HAYES: So we've seen some variation in use of services by type of service and by geographic area. So the question now is whether we can explain those different patterns in growth. Recall back in November we talked about a workplan for this topic and the thought was that we would try and identify various factors that might explain growth in use of services, analyze some data to see which factors are most important, and then if appropriate, identify some policy options that the Congress or CMS might consider. So this initial step here represents our effort to fulfill that plan.

We can think of a number of different factors that might affect growth in use of physician services. We've talked about some of them this morning. We talked about some of them just now. Things like technology diffusion, changes in practice patterns. The Commission has been concerned over the years about shifts in the site of care and so on. So all of these things could conceivably play a role in the growth patterns that we see.

As a first step in trying to pursue these different factors we have focused on this matter of professional liability or medical liability, whatever term you prefer. The idea here is that because of fear of medical liability suits it's possible that physicians are ordering extra tests and procedures just to protect themselves and practice what has been termed defensive medicine. We chose this topic for different reasons. Part of it has to do with the availability of information on the subject and I'll get to that in a second. But the other is that this topic does illustrate the way that we can proceed from a topic that might affect use of physician services through some kind of an analysis and ultimately maybe some recommendations regarding policy.

So looking at this first bullet here our question for now is do areas with higher professional liability insurance premiums have higher growth in use of physician services? As you can see here, we're using this idea of professional liability insurance premiums as an indicator of the risk of medical liability lawsuits. Certainly, we would expect that the level of these premiums is determined in large part by the number of lawsuits in an area and the amount of awards in those lawsuits.

From an analytical perspective we've gone about trying to address this question by using as our measure of PLI premiums the geographic practice cost index in the physician fee schedule for PLI. This is an index that CMS maintains. It's based on collection of data on PLI premiums for the different payment localities that Medicare uses. You can see once again we're focusing on imaging services as a high growth type of service.

MR. DeBUSK: Kevin, a certificate of need will come into play, which states have certificates of need and which don't, because that's going to determine the number of units in that state.

DR. HAYES: Sure. There are many, many factors that we can pursue. There was talk this morning about supplemental insurance coverage. There's just a long list of possible candidates that might help us understand why use of services is what it is. I think the goal here is to go through analyses of these different factors and we hope get to the point where we achieve a level of understanding of what the more important factors are and then we can turn the Congress and say, okay, if you're worried about these factors, here are some recommendations from a policy standpoint you might consider, given that understanding of the important factors as a backdrop.

So let's just talk for a second about this PLI GPCI that we have available to us. This index varies by payment locality and it ranges from a low -- the GPCI itself is centered around a value of one. It ranges from a low of 0.28 to a high of 2.7. 0.28 is in South Carolina. The whole state is a payment locality. And 2.7 is the GPCI for the city of Detroit, just to give you an ideal of what we're dealing with here.

If we then say, what do we see when we try and compare the GPCI and use of imaging services? This table gives you a first pass at our results. It's structured pretty much the same way as the table that Chantal showed in that we have classified payment localities into quartiles based on the value of this GPCI. The second column over here you can see what the average level of the GPCI is for each of the localities ranging from 0.5 up to 1.4.

That next column over is interesting in that it begins to show us what might be some kind of a relationship between use of imaging services and the level of the GPCI. We can see a steady increase here from 69 on up to 101. Before we proclaim this as the answer I'll just alert you to the fact that I've got some caveats to talk about in just a second or so. But in any case, this is an interesting result and prompts us to look further in this area.

The next column over shows the average rate of growth in imaging services, use of imaging services for each of the quartiles. We see the highest rate of growth is for the first quartile; the quartile with the lowest average service use. Then we see a decrease in the growth rates down to 7.9 in quartile four. There is a negative correlation. If we calculate a correlation coefficient for this we get a coefficient of minus 0.22. But when we look at the individual quartiles the relationship is a little less clear and that we've got quartile three there misbehaving with a growth rate of 9.4. So that breaks up any clear trend that we might see here. But nonetheless, there is some kind of a relationship there.

Then finally we have the contributions to overall growth of the type that Chantal showed. I'd just point out here that we've got -- the first quartile is contributing 2.2 percentage points to our total of nine, but then the fourth quartile is making the same contribution. That once again shows that combination of the baseline use rate working with the average annual growth rate and you can get a high contribution to the overall growth with this combination of either low baseline, high growth or high baseline, low growth.

Our next slide then just lists some of the caveats that we'd want to put on all of this. The first thing would have to do with the limitations of our measure of PLI premiums, this GPCI from the fee schedule. There are a couple of things to point out about this. The first is that ideally we would have a measure of premiums that is for the physicians, the physician specialties, that are actually ordering these imaging services. But we don't have that. We just have the indicator for all physician specialties.

The other thing that we would really like to have is some sense of how these premiums are growing. After all, our primary interest here is in growth in use of physician services and it would be nice to have a compatible measure of PLI premiums, risk of medical liability suits, whatever it is. But once again, we just have this GPCI. It's an average for three years, 1996 through 1998, but it doesn't represent any kind of a growth in premiums type of measure.

Finally just coming back to that point about the data used to determine the GPCI, that is from '96 to '98. I'll just point out this one graph that you've seen before, something we put in the March report. It has to do with growth in PLI premiums over time. You can see by looking at this that with data from 1996 through 1998 we were in a period when premiums were declining or flat perhaps, but since then, certainly for the period for which we have the use of services data, premiums were going up. It could be that imbedded in those growth rates that you see here there have been some differentials by payment locality. We just don't have that. It would be nice to have more recent PLI premium data. CMS is working to collect better information but we won't have that in time for the June report.

The other important thing to point out about this has to do with the views of some that this relationship between PLI and use of services could work in different directions. Our hypothesis here is that risk of a medical liability suit is what is leading to use of imaging services. But it's possible that the relationship works the other way. That greater use of services presents more opportunities for errors and that is what is leading to the PLI premiums that we see. Or it's some combination of the two, that we have a dual multidirectional relationship going on here. So it's an interesting situation that we confront when we look at something like this.

So that then brings us to what we might do in the way of policy options and how we might use analyses like this to develop policy options. What I would say about this is that ultimately after we've looked at a number of these factors we might come up with some policy options that would fall into two different groups. One group would have to do with payment policy. Perhaps we would come up with some suggestions for how Medicare pays for physician services working through the fee schedule or some other mechanism like that.

The other possibility is that we would consider broader approaches outside of payment policy, disease management, for example. Karen Milgate will be presenting a paper tomorrow on using incentives to improve quality of care. If we think that maybe some use of services involves overuse of services, and if we view overuse of services as a quality problem, then maybe some of the ideas that Karen will be talking about are a relevant source of options for us to consider.

Then there is the matter of the ambiguous results that we get out of an analysis like the one that we've conducted so far having to do with this possibility of a dual relationship between the factor that we're looking at and use of physician services. It raises the question then whether we should rely just on this approach to reaching policy recommendations and whether we want to just address some specific issues and develop targeted options, kind of moving along on a parallel track.

The next steps for us in this effort involve further analyses of factors affecting use of physician services, technology, shifts in site of care, the patterns and billing codes used to report services provided to Medicare beneficiaries, and so on. Then ultimately we would consider policy options as appropriate.

That's all we have.

MS. BURKE: As has been the case with all of these this morning it has been quite useful and I think gives us a framework for a terrific discussion. One of the things I wondered about as you were building a set of criteria to examine that might have an impact, not inconsistent with where Jack was going, I wondered about the presence of specialties, and the distribution of specialties and whether or not both the number of physician as well as their mix isn't a contributing factor. The presence of cardiologists, the presence of radiologists, pathologists, anesthesiologists. As you like at the imaging area as one of the areas of growth, the presence of a large number of specialists who either have available to them, as Jack suggests, new imaging capacity because of growth in that or just as the nature of their practice, whether we know today whether the shifts that we saw occurring early on between the different groups of physicians as we tried to examine that previously, whether that still exists and what its impact is.

DR. HAYES: We do have pretty good information on the supply of physicians by geographic area, so that's certainly the kind of thing that we can pursue, and there's pretty fine level of detail in terms of the specialties as well as just numbers of physicians.

DR. STOWERS: Kevin, I just wanted to open up this PLI thing a little bit further. I think there's a difference in the PLI market where the risk, and therefore the premiums, are higher and stable over time. You would expect there to be less growth. But I think what's happened here, and I think you're absolutely right the secret is probably in the change in the numbers from '99 to '01 because if you look on the map you've got Mississippi, the Carolinas, Pennsylvania, some of the traditionally very low PLI states that are in the middle of the crisis with quadrupling of their premiums. What's happening there is, I think the 11.1 percent growth makes perfect sense there in the use of their services because they're suddenly finding themselves changing from a low-risk PLI market to a very high-risk PLI market, and therefore you would expect that kind of response.

So I think if we look at stable situations and growth situations where there's been a change in the PLI, I think this is all going to make a lot more sense and probably confirm a lot more the fact that as the market changes to be higher risk you will see an increase in the growth. So I think we've got to get growth to growth there in looking at that.

MR. SMITH: Two points. Again, I found this very useful, Chantal and Kevin. This continues a day of useful stuff.

I wanted to make Sheila's supply point just as one of the things we ought to take a look at. But the other one that struck me looking at this map and trying to do a crude effort of figuring out what it told us, it also seems to me that beneficiaries characteristics may be very telling here. Intensity seems to me to line up with what we know about retirement communities. Even Pennsylvania is interesting, Ray. It's got the oldest population in the country. And you mentioned some of the other beneficiary characteristics, access to the supplemental market. So things are going to line up in varying ways and I suspect we're going to find a multiplicity of causes here.

I would be a little bit careful about getting too far down the PLI limb before we look and see whether some other stuff tells us both as much and as little as that does.

DR. HAYES: I should point out this was meant to be an illustration of the sequence that we hope to go through with all these where we start out with a factor and see what the relationship looks like. Ultimately we're going to have to put all this together and sort it out and figure out which ones are more important and which ones are less. We hope that the most important ones then become the focal point, as appropriate, for policy options.

DR. NELSON: I again want to urge that we avoid a conclusion that volume growth is somehow evil and that policy should be directed toward controlling it, because certainly that's not the case with less invasive cardiovascular procedures or colonoscopy or osteoporosis screening or other things in which we seek to increase volume appropriately. And probably that's true of some imaging services as well.

Secondly, you mentioned a shift of site of service and particularly with respect to imaging that may be a factor where previously more was done in the hospital and both the technical and professional components were separated and part billed to Part A. Now with freestanding imaging centers more and more will be both going to Part B. Now how much of it's appropriate or inappropriate is another issue, but I'm talking mainly to make sure that we don't include numbers that ought to be excluded.

The same could be said for drugs that are covered under Part B.

The third thing, I'd just underscore someone else said about avoiding connecting PLI with volume. It's hazardous because of the multiple additional factors. Probably the most important factor in volume in my view are the availability of facilities, services, and the marketing of those services. You certainly see that with direct to consumer advertising of not only imaging capability but also of some physician-provided drugs.

MS. DePARLE: I agree with Alan, I think it's important that we not - and I don't think you have so far -- draw conclusions from the data about appropriateness or inappropriateness. I guess I wonder if we'll be able to get to that point by June. You've done a lot of work but it seems like there's still a lot to be done here. In particular, in the paper that you wrote you talk about looking at growth in service use by site of service. Alan alluded to this as well. You have some data about the growth of IDTFs but I remember seeing something recently about the growth in the performance of non-invasive imaging in physicians' offices as opposed to referring out to either hospitals or IDTFs. What sticks in my mind was something like more than 50 percent of the procedures now being performed by non-radiologists are in those other settings.

So I wondered if you had begun to look at that. And if so, do you have any data on that yet?

DR. HAYES: We can look at the setting where services are provided. It turns out that there's not a lot of difference, I think it's fair to say this, between IDTFs and physicians' offices in the sense that they tend to be the same kinds of places, it's just that it's a difference in designation, one versus the other.

The other thing I'd point out is that since we wrote the paper even we have been looking at what seems to be a pretty extensive -- I won't say extensive but there is quite a body of work out there on this issue of self-referral. Is that what you're thinking about?

MS. DePARLE: Yes. So when I said -- I think there is a distinction between IDTFs and physicians' offices, if you can drill down into this, because there are physician offices where the referring physician is doing the procedure in his or her own office. My understanding is that that has grown a lot in the last few years. In that sense I think an IDTF would be different because those places are not -- those are typically staffed by radiologists and my understanding is that a lot of the growth has occurred in the non-radiologist offices.

DR. NELSON: What's IDTF?

MS. DePARLE: Independent diagnostic treatment facility.

DR. HAYES: The claims files have the variables that we need to find out who the referring physician versus the physician who was providing the service. We just need to work with those variables and see if they'll tell us anything. We just don't know about the quality of the information.

MS. DePARLE: I think I said that wrong. It's diagnostic testing facility, not treatment.

MR. HACKBARTH: Just a word about the time frame here. I think we're still very much in the research mode here and I think we certainly will be through June and beyond. Whether we will uncover anything that we think is worthy of a policy proposal or not, I don't know. But if we do it would be for the next year's cycle. We would be working towards next March's report. So although we're trying to publish a useful price of work for June, we've got much more time than that to explore carefully this area.

DR. ROWE: I think this is very interesting. Putting my clinician hat on I'd like to make a recommendation I think might clean up the analysis a little bit. If you look in Table 1 of your chapter, you list the basket, if you will, of imaging procedures that you're including in this imaging global measure. If you think about it, defensive medicine, if it exists, is not really doing chest x-rays. They've always been there. And it's not doing plan x-rays of the musculoskeletal system. It's really doing CAT scans when people have a headache even though the neurological examination suggest that there's nothing serious and they don't have a history of a seizure of a severe head injury of something. It's doing the MRI because somebody really wants one. Somebody wakes up with a sense of having a dread disease so it's doing the total body CAT scan just to make sure everything is okay, et cetera.

I think that you could clean it up a lot if you went down this list of imaging and you took out some of these things that probably aren't really relevant to your defensive medicine hypothesis. You could just do CAT scans and MRIs of the head and elsewhere and put those four together as a kind of variable, and then do your analysis. You might see it clean up dramatically because the regular chest x-ray would fall out. Maybe cardiac imaging I would buy. I can't believe people are doing lots of cardiac caths on people who don't have any reason to have a cardiac cath. That's hard to imagine because people die from cardiac caths. At a very low incidence, but they do. So it's really hard to imagine that there's much of that.

So really the issue is to be a little more selective and create a secondary, maybe advanced imaging category. I think that may clean things up a lot here.

MR. MULLER: Again I'll join in the compliments for the quality of the work. A couple of comments. In terms of the relationship of whether the liability leads to more testing and more testing leads to liability. There's been work done over the last 10 years in those Harvard studies -- and those are hospital-based so they don't apply to all physician locations -- that indicates that a relatively small proportion of incidents lead to malpractice. It's considerably under 20 percent. Sometimes you look at four, 10, 12. So the likelihood -- there obviously are intervening variables between incidents and liability. So it's probably not that likely that more -- by that logic, that the greater number of incidents would lead to greater liability in that sense because there's just so many things that happen in between the incidents and a liability claim being filed.

Secondly, and Jack and Alice and others may comment, but my sense is over the last eight, 10 years the price of imaging has gone down quite a bit in the private market. I don't know what the Medicare prices are. You pointed out the prices for physician service in general, but I don't know what the -- I can't remember now what the imaging prices are for Medicare. But with that considerable price competition and in the rest of the world price going down sometimes does lead to more use, so my sense is part of the explanation can be not just the one that Nancy was suggesting in terms of the facilities being out that but there's a very remarkable drop in price, I think of the order of 75 percent in some of these in the last few years.

DR. HAYES: You're talking about the cost of the equipment.

MR. MULLER: No, the price that private insurers pay for this imaging as opposed to Medicare. I don't know what the Medicare rates have been over this period but the price paid, whether by self-pay or by private.

I just have a brief question of Jack. I agree with his sense of reclassifying the imaging base. But my sense is the kind of geographic variation work that was discussed this morning indicates that the CATs, in fact there's quite a bit of a variety, variation in CATs so they may in fact not just be always driven by pure -- so that you may want to keep them in or not. I don't have a definitive opinion, I'm just really more asking a question of that. But I would definitely look at the price variable because I think the proliferation of these devices has -- you can't get them for $49 like Earl Scheib but you can get pretty close.

DR. NEWHOUSE: I guess I had a reaction somewhat similar to what I read as Glenn's, which was I wasn't clear where this was going at end of the day or how we were going to interpret it. I think consistent with Ralph's remarks about price, this kind of slide I think one could say this is where technological change is occurring. It's hard to make any normative judgment about whether this is good, bad or indifferent.

I also found it hard to interpret the growth rates because I would have thought over -- generally they were over a two or three-year period. I would have thought there's got to be a fairly large random component in that short a time period about just where particular providers go in, and where Jack's new facilities come in. I, frankly, didn't quite know what to make of it.

Then going back on a minor point, going back to a discussion we had this morning about the geographic variations, I think the growth numbers here are presumably resident-specific, right? And the PLI numbers are provider-specific? So you have some across interference there.

MS. ROSENBLATT: Just a quick point. I too thought the chapter was good and I liked the idea of zooming in on the procedures that are increasing in volume, like you've done with the imaging. Just one comment on the medical liability. Those premiums are also going to reflect the regulatory environment in the state. Like some states have a cap, so that might be distorting the analysis.

MR. HACKBARTH: Any others?

DR. ROWE: A cap on?

MS. ROSENBLATT: The award, like California has a $250,000 cap, so that's going to affect the premium obviously.

MR. HACKBARTH: As opposed to claims.

DR. ROWE: But I think if we start adjusting the -- the premium is probably more influenced by stock market performance than it is by number of claims or presence of a cap. If you really look at why premiums are going up, it's as much because the market has gone down for three years than it is changes in the number of awards, malpractice awards. So it's a hard thing to start to adjust.

MR. HACKBARTH: Any others?

Okay, thank you, Kevin, Chantal.